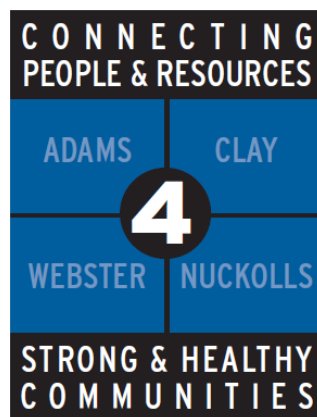


The South Heartland District Community Health Improvement Plan 2013 - 2018

A Four-County Plan for Public Health Partners and Stakeholders to
Improve the Health of South Heartland Residents



Approved by the South Heartland District Board of Health
November 6, 2013

Peggy Meyer, MSW, LMHP; Chair, SHDHD Board of Health
Michele Bever, PhD, MPH; SHDHD Executive Director



Adams, Clay, Nuckolls and Webster Counties in Nebraska

Acknowledgements

The staff at South Heartland District Health Department would like to recognize the many community partners who contributed to the development of this plan. Community members, educators, government officials, service organizations, health care providers and many more participated in a district-wide process called *Mobilizing for Action through Planning and Partnerships* (MAPP). Their input and commitment were instrumental to a productive and successful MAPP process and the completion of the Community Health Improvement Plan (CHIP). We also are indebted to the external MAPP Core Team members, who provided guidance, advice and county-level assistance throughout this process. The assessments and planning were supported by funds from the Nebraska Department of Health and Human Services Office of Community and Rural Health, Brodstone Memorial Hospital, Webster County Community Hospital and Mary Lanning Healthcare.

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Dear South Heartland Partners and Residents,

Every five years South Heartland convenes a community-informed public health assessment and facilitates development of a Community Health Improvement Plan. During 2011 and 2012, residents, community service organizations, health care providers, government officials, education professionals, business and civic leaders, and many other partners in the public health system came together across our four counties to identify forces of change, strengths, and opportunities in our communities and in our local public health system. With a shared purpose of “Connecting People and Resources for Strong and Healthy Communities in Adams, Clay, Nuckolls and Webster Counties,” we worked collaboratively to review data about our communities and to study our health status. Next, we prioritized health concerns to work on together over the next five years. Finally, we identified strategies for addressing each of these priorities.

The resulting ***South Heartland Community Health Improvement Plan 2013–2018*** has five health priority areas: Obesity, Cancer, Mental Health, Substance Abuse, and Access to Health Care. With our many partners who participated in the assessment and planning, and others who may join us as we implement the plan, we seek to improve the health and quality of life of South Heartland residents by focusing on these priorities. It will take a collective effort to reach the goals laid out in this Community Health Improvement Plan. We hope you will join us in our collaborative work to improve the health of our communities and that you will find a place in this plan where you can contribute to these efforts.

Sincerely,

Michele M. Bever, PhD, MPH
Executive Director
South Heartland District Health Department

Assessment and Plan Development Process: A Brief Summary

South Heartland District Health Department's regular five-year public health assessment and planning process is an important component of meeting the public health core functions and essential services, especially Essential Service 1: Monitor health status and understand health issues facing the community, Essential Service 4: Engage the community to identify and solve health problems, and Essential Service 5: Develop policies and plans that support individual and community health efforts.

Mobilizing for Action through Planning and Partnerships (MAPP) is a strategic approach to community health improvement. South Heartland District Health Department used this tool to facilitate the four-county health district in efforts to improve health and quality of life through community-wide and community-informed strategic planning. This process helped the district identify and plan use of resources, taking into account the unique circumstances and needs of the district and the individual component counties. It also promoted new and solidified existing partnerships in our communities and across the district.

The phases of the MAPP process are: Organizing/Partnership Development, Visioning, Assessment, Identifying Strategic Issues, Formulating Goals and Strategies, and the Action Cycle for the resulting Community Health Improvement Plan (CHIP). A CHIP can only be adopted and realistically implemented if the community has contributed to the plan development. SHDHD worked to ensure participation by a broad cross section of the district, inviting representatives from many sectors of our communities.

Following the assessment phase, the community (through stakeholder work groups) identified strategic issues and formulated goals and strategies for addressing each issue. Community stakeholders collaborated in a facilitated development of this Community (district-wide) Health Improvement Plan, aligning goals and strategies with state and national plans, and considering strategies that targeted different levels of the Health Impact Pyramid (see below).

In 2013 and beyond, work groups for each priority will move the plan components into the Action Phase (CHIP Implementation Phase), with oversight and evaluation planning from the MAPP/CHIP core team, which will continue to meet 1-2 times a year for the duration of the CHIP.

More information on the comprehensive assessment and priority setting process is contained in the companion document *The South Heartland District Community Health Needs Assessment 2012: A Four-County Needs Assessment using the Mobilizing for Action through Planning and Partnerships (MAPP) Process*.

Public Health Core Functions and Essential Services

(1) Core Public Health Function: Assessment

Essential Service 1: Monitor health status and understand health issues facing the community.

What's going on in our District? Do we know how healthy we are?

Essential Service 2: Protect people from health problems and health hazards.

Are we ready to respond to health problems or threats? How quickly do we find out about problems? How effective is our response?

(2) Core Public Health Function: Policy Development

Essential Service 3: Give people the information they need to make healthy choices.

How well do we keep all people and segments of our district informed about health issues?

Essential Service 4: Engage the community to identify and solve health problems.

How well do we really get people and organizations engaged in health issues?

Essential Service 5: Develop policies and plans that support individual and community health efforts.

What policies promote health in our district? How effective are we in planning and in setting health policies?

(3) Core Public Health Function: Assurance

Essential Service 6: Enforce laws and regulations that protect health and ensure safety.

When we enforce health regulations are we up-to-date, technically competent, fair and effective?

Essential Service 7: Help people receive health services.

Are people receiving the medical care they need?

Essential Service 8: Maintain a competent public health workforce.

Do we have a competent public health staff? How can we be sure that our staff stays current? How are we assisting our community and professional partners to stay current on public health interventions and evidence-based practices?

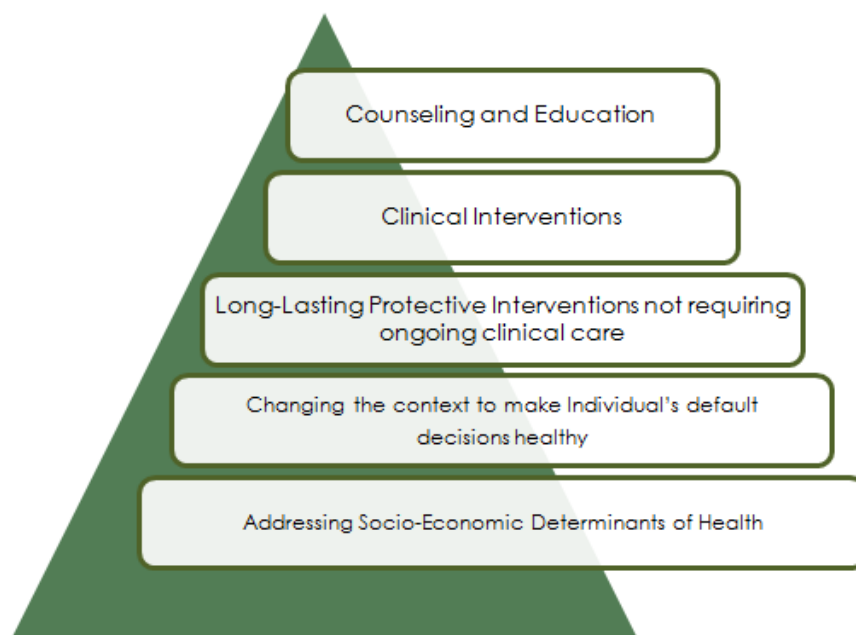
Essential Service 9: Evaluate and improve programs and interventions.

Are we doing any good? Are we doing things right? Are we doing the right things?

Essential Service 10: Contribute to and apply the evidence base of public health.

Are we discovering and using new ways to get the job done?

Community Health Improvement and the Health Impact Pyramid



American Journal of Public Health, 10.2105/AJPH.2009.185652 April 2010, Vol. 100, No. 4

The Health Impact Pyramid¹

The five-tier pyramid is a conceptual framework for public health action.¹ Efforts to address socioeconomic determinants are at the base and can affect the health of the greatest number of people. Examples of these determinants include poverty and education. Next are public health interventions that change the context for health (e.g., clean water, safe roads, elimination of lead exposures, and eliminating artificial *trans* fat in food). Next higher in the pyramid are one-time or infrequent protective interventions with long-term benefits (e.g., immunizations, colonoscopy, smoking cessation programs). Direct clinical interventions (e.g., blood pressure and cholesterol control medications) can be limited in their overall population impact due to lack of access and lack of adherence, among other factors. At the top of the pyramid are counseling and education efforts, which are designed to help individuals rather than an entire population. These approaches tend to be least effective and have limited public health impact due to their dependence on long-term individual behavior change, especially if there is no context or environment where healthy choices are the default actions. However, when applied consistently and repeatedly, educational interventions may be effective.

“Comprehensive public health programs should generally attempt to implement measures at each level of intervention to maximize synergy and likelihood of long-term success.”

- Thomas R. Frieden, MD, MPH, Director, Centers for Disease Control and Prevention

¹ Frieden, TR., 2010. A Framework for Public Health Action: The Health Impact Pyramid. American Journal of Public Health. Vol.100 (No. 4): 590 – 595.

Community Health Improvement Plan

Priority Goals

Goal 1: Obesity

Reduce obesity and associated chronic disease risk through consumption of healthful diets, daily physical activity and achievement and maintenance of healthy body weights

Goal 2: Cancer

Reduce the number of new cancer cases as well as illness, disability and death caused by cancer

Goal 3: Mental Health

Improve mental health through prevention and by ensuring access to appropriate, quality mental health services

Goal 4: Substance Abuse

Reduce substance abuse to protect the health, safety, and quality of life for all, especially young people

Goal 5: Access to Health Care

Improve access to comprehensive, quality health care services



Priority Goal: Obesity

Goal 1: Reduce obesity and associated chronic disease risk through consumption of healthful diets, daily physical activity, and achievement and maintenance of healthy body weights

Targets/Performance Measures

Short-term: Local targets were set to achieve a 6% improvement over the next 6 years, consistent with the target of 10% change over 10 years set by Healthy People 2020.

- Increase the percentage of adult consuming five or more servings of fruits and vegetables daily
Baseline: 22.9% (State 21.1) BRFSS, 2009-2010
Target: 24.3%
- Increase the percentage of youth who report eating fruits ≥ 2 times/day and vegetables ≥ 3 times/day during the past 7 days
Baseline: 23.4% fruits (State 27%), 8.5% vegetables (State 12%) (YRBS, - SHDHD 2012, State, 2011)
Target: 24.8% fruits, 9% vegetables
- Decrease the proportion of high school students who report consuming soda one or more times per day during the past 7 days.
Baseline: 21.1% (State, 26%) (YRBS, - SHDHD 2012, State, 2011)
Target: 19.8%
- Increase the percentage of adults/youth meeting the 2008 Physical Activity Guidelines for Americans
Baseline: 49.1% (State, 49.0%) of adults reported 30 min of aerobic activity 5 days of the week (BRFSS: SHDHD, 2011 State, 2011)/ 58.7% (State, 54%) of youth reported 60 minutes of physical activity 5 days or more per week (YRBS, - SHDHD 2012, State, 2011)
Target: 52% adults reporting 30 min, 5 days per week / 62.2% of youth reporting 60 min. of PA 5 days or more per week.
- Increase the number of mothers who meet the recommendations for breastfeeding (exclusive for 6 months)
Baseline: (no data available for general population about duration)
Target: collect duration data for the general population

Long-term:

- Decrease the percentage of adults 18+ years who are overweight or obese (BMI ≥ 25.0)
Baseline: 68.7% (State, 65%) (BRFSS, 2012)
Target: 64.6%
- Decrease the percentage of adults who are obese (BMI ≥ 30.0)
Baseline: 30.6% (State, 28.6%) (BRFSS, 2012)
Target: 28.8%
- Decrease the percentage of children under 18 years who are overweight (BMI ≥ 25) or at risk of becoming overweight ($21 < \text{BMI} < 25$)
Baseline: Overweight or Obese 32.1% (State, 26.5%) (YRBS, 2012)
Targets: Overweight or Obese 30%

Obesity Prevention Strategies

O-1. Community Partnerships: Increase the number of community partners involved in the implementation of the Community Health Improvement Plan (CHIP).

Setting: Community

- A. Expand Obesity Prevention Coalition to include representation from a range of health providers, organizations providing services for underserved populations, parent support organization, businesses (e.g., Chambers of Commerce, grocers, restaurants), insurance brokers, athletic trainers, colleges, schools and school boards, PTOs, educational service unit, child care facilities, Veteran's Services, faith- and community-based organizations, health/wellness organizations, city and county government decision-makers, food banks/pantries, and others needed to support the strategies in this plan

O-2. Community Context: Increase opportunities for active living and healthful diets in our local communities.

Setting: Community

- A. Promote community planning that includes a focus on health
- Support development of comprehensive community plans that promote active living and safe environments including coordination between planning, transportation, health and parks departments to enhance the build environment (e.g., trail systems, parks, green space and sidewalks in new housing developments, safe non-vehicular routes to community points of interest)
 - Advocate for policies and actions that create safer environments to be active (e.g., improved sidewalks/bike lanes, Safe Routes to School, Complete Streets policies)
 - Identify resources to support community planning (e.g., Safe Routes to School, NE Department of Roads)
- B. Support the creation, improvement and promotion of community-based facilities and events that provide opportunities for physical activity and healthful diets (community centers, parks, fitness centers, farmer's markets, community gardens, grocery stores)
- Identify, promote and secure resources (e.g., community foundations, Farm Service Agency, hospitals)
 - Identify and promote partnerships and model policies (e.g., school/community agreements for facility and equipment use)

O-3. School Context: Increase opportunities for active living and healthful diets in our local schools and childcare centers.

Setting: Schools, childcare facilities

- A. Identify and implement school-based programs and policies that promote physical activity and healthful diets.
- B. Research school and childcare center practices related to nutritional offerings and physical activities not linked to organized sports (e.g., food reward policies, vending machine offerings, time allotted to physical activity by grade) and promote best practices and implementation of model policies.
- C. In partnership with school staff, monitor physical activity and nutrition indicators in children in educational settings, then use these data to educate students and parents and to support policy adoption

O-4. Worksite Context: Increase opportunities for physical activity and nutrition at worksites.

Setting: Worksites

- A. Promote adoption of successful models for worksite-based wellness
- Determine baseline and expand number of worksites doing health risk assessments and using these to promote policy, system and environment changes
 - Determine baseline and increase number of worksites with model worksite wellness polices (including breastfeeding model policies)

- B. Engage small businesses and self-employed populations into discussions about wellness initiatives (e.g., healthy meeting guidelines)

O-5. Empowered People: Empower the general public, referral agents, and communities to connect with and recruit needed resources and share reliable health information.

Setting: Community

- A. Use evidence-based small media/group education to reach target populations with accurate and consistent messaging that raises awareness and promotes physical activity and healthful diets through community partners and events.
- Provide educational, activity and screening opportunities to target populations: health fairs, nutrition classes and instruction on where food comes from, fitness and nutrition events for children and youth, for seniors, for parents and for underserved populations
 - Engage local grocery stores in activities that promote healthy diets (partnerships between hospitals and grocers: store tours, cooking demos, dieticians on-site, cost information for healthy foods, Go Local to promote local produce, etc.)
 - Explore role of health providers in empowering patients (to include wellness screening as part of physical exams, to provide wellness coaching, and to “prescribe” healthful diets and physical activity, and to offer informational videos in waiting rooms.
 - Encourage food banks/pantries to request healthful food donations, offer vouchers for fresh fruits and veggies, and provide healthful recipes

Priority Goal: Cancer

Goal 2: Reduce the number of new cancer cases as well as illness, disability, and death caused by cancer.

Targets/Performance Measures

Screening: “Appropriate” screening methods are based on most recent recommendations by the U.S. Preventive Services Task Force (U.S.P.S.T.F.). Local targets were set to achieve a 6% improvement over the next 6 years, consistent with the target of 10% change over 10 years set by Healthy People 2020.

- Increase percentage of women aged 50-74 years who are up-to-date on breast cancer screening (mammogram within the last 2 years, U.S.P.S.T.F. , 2009)
Baseline: 70.0% (State 69.9%) BRFSS, 2012
Target: 74.2%
- Increase percentage of women aged 21-65 years who are up-to-date on cervical cancer screening rates (women without hysterectomy who had pap test within the last 3 years, U.S.P.S.T.F. , 2012)
Baseline: 80.4% (State 83.1%) BRFSS, 2012
Target: 85.2%
- Increase percentage of adults aged 50-75 years who are up-to-date on colorectal cancer screening (annual fecal occult blood test (FOBT), OR sigmoidoscopy every 5 years + FOBT every 3 years, OR colonoscopy every 10 years, U.S.P.S.T.F. , 2008)
Baseline: 57.1% (State 63.6) BRFSS, 2012
Target: 60.5%
- Developmental: Increase the proportion of men 40 years and older who have discussed with their health care provider the advantages and disadvantages of the prostate-specific antigen (PSA) test to screen for prostate cancer (U.S.P.S.T.F. guidelines of May 2012)
Baseline: Local baseline unknown; 2010 National Baseline = 14.4% (NHIS, CDC/NCHS)
- Developmental: Increase the proportion of youth and adults who follow protective measures that reduce the risk of skin cancer

Incidence/Mortality: Rates based on 100,000 population (Nebraska Vital Statistics, source years: Incidence 2003-07; Mortality 2004-08)

- Reduce incidence / mortality rates due to Female Breast Cancer
Baseline: 128.9 (state 123.2) / 19.0 (state 22.0)
Target: 121.2 / 18.0
- Reduce incidence / mortality rates due to Cervical Cancer
Baseline: 9.9 (State 7.2) / 0.0 (State 1.8)
Target: 9.6 (incidence)
- Reduce the incidence / mortality rates due to Colorectal Cancer
Baseline: 64.7 (state 56.2) / 15.5 (state 18.5)
Target: 60.9 / 14.6
- Reduce incidence / mortality rates due to Prostate Cancer
Baseline: 161.3 (state 158.9) / 25.1 (24.5)
Target: 151.6 / 23.6
- Reduce incidence / mortality rates due to Skin Cancer
Baseline: 18.5 (state 17.1) / 4.6 (State 3.0)
Targets: 17.4 / 4.3

- Reduce incidence / mortality rates due to Lung Cancer
Baseline: 66.2 (state 65.6) / 48.2 (state 47.2)
Target: 62.3 / 45.3

Cancer Prevention Strategies

C-1. Community Partnerships: Increase the number of community partners involved in the implementation of the Community Health Improvement Plan (CHIP)

Setting: Community

- A. Expand the local Colon Cancer Coalition to encompass all cancers and increase the number of local community members involved in the Cancer Coalition (cancer providers, survivors, representatives from organizations providing services for populations with low incomes, and representatives from organizations serving as community connections and communication channels for traditionally underserved populations)
- B. Increase # of organizations providing services and resources for populations with low incomes
- C. Increase # of organizations serving as community connections and communication channels for traditionally underserved populations.

C-2. Prevention & Screening: Increase the number of community members who actively participate in recommended prevention/screening activities

Setting: Community, health care, schools, worksites

- A. Use evidence-based small media/group education to reach target populations with accurate and consistent messaging about cancer prevention/screening through community partners and events
 - Radon awareness and low cost testing
 - Colorectal cancer education and FOBT kit distribution
 - Tobacco free activities
 - Breast cancer and breast cancer screening education - EWM project
 - Nutrition/physical activity initiatives
 - Identify/recruit local prevention champions for each cancer type (providers and/or survivors)
 - Deliver easy-to-understand explanations about cancer screenings and other preventive health benefits under the Affordable Care Act.
 - Support health literacy initiatives
- B. Develop local community health worker program/system as a link between providers of cancer prevention/screening services and target populations.
- C. Pursue funding or appropriate partnerships to provide recommended cancer screening services for those not covered by EWM, included those with high deductibles.

C-3. Survivorship: Increase the duration and quality of life for cancer survivors in our communities

Setting: Community, health care

- A. Assist seniors in accessing healthcare and related support services for cancer care (e.g., managed care plan assistance, partner development and referral, MAA programs).
- B. Partner to increase the number of local program offerings that provide support for survivors (e.g., A Time to Health, Reach to Recovery, ACS Transportation Program, YMCA's LiveStrong nutrition and physical activity, Living Well chronic disease management training, MLH survivorship care planning, ACS Library, etc.).

C-4. Empowered People: Enhance the ability of the general public and referral agents to connect with needed resources related to cancer prevention and health.

Setting: Community, health care, social media

- A. Partner in the development of a database system/search engine of local information for public and referring organizations and include links with regional, state and national cancer resources (e.g., VNA Financial Assistance Program, ACS, Komen Nebraska) and investigate Apps for access via mobile phones.
- B. Collaborate with the local library system to enhance available healthy living resources and serve as a channel for educational healthy living programming and cancer resources (e.g., Cancer Corners program through Nebraska Cancer Coalition) and use librarians as information brokers (e.g., Hastings Public Library, Republican Valley Library Association, school librarians, school computers, Bookmobile to nursing homes).



Priority Goal: Mental Health

Goal 3: Improve mental health through prevention and by ensuring access to appropriate, quality mental health services

Targets/Performance Measures

Local targets were set to achieve a 6% improvement over the next 6 years, consistent with the target of 10% change over 10 years set by Healthy People 2020.

Mental Health Outcome Targets:

- Reduce the proportion of persons who reported currently experiencing depression (based on a Severity of Depression score of 10 or more)
Strategy: Screening Across the Lifespan (behavioral health, substance abuse, suicide)
Baseline: 5.2% / State 8.7% BRFSS, 2008 (difference not significant)
Target: 4.9%
- Reduce the proportion of adults reporting Serious Psychological Distress (SPD) in the last 30 days
Strategy: Screening Across the Lifespan (behavioral health, substance abuse, suicide)
Baseline: 7.0% / State 2.4 BRFSS, 2008 (difference is significant)
Target: 6.6%
- Reduce reported suicide attempts by high school students during the past year.
Strategy: Screening Across the Lifespan (behavioral health, substance abuse, suicide)
Baseline: 9.6% (YRBS, 2012) / (State 8.0%) YRBS, 2011
Target: 9.0%

Access Targets:

- Increase the proportion of primary care facilities that provide mental health services onsite or by telehealth.
Strategy: Integrated Care (HRSA Integrated Care Project)
Baseline: 4 of 14 clinics
Target: 7 clinics
- Increase access to mental health assistance/services through local educational institutions and worksites.
Strategy: Recruit Additional Community Partners (School Admin/Boards, Employers);
Strategy: Education, Awareness, Promotion; **Strategy:** Mental Health First Aid
Baseline: 3 Trainers, 2 Trainings, 60 Trained, Target Groups Reached: Law Enforcement (35), Behavioral Health (25)
Target: Developmental
- Increase the number of mental health patients who participate in recovery support programs (i.e., NAMI peer support, Community Support, support groups, VA-sponsored programs, Vocational Rehab, etc.)
Strategy: Increase promotion of recovery support providers at community events such as Vital Signs, Hastings home page, Midland area for Aging etc.
Baseline: Identify partners who track data- contact for baseline
Target: improve by 6% over the next 3 years
- Increase collection and accessibility of local mental health data.
Strategy: Resource Network / Database
Baseline: Potential sources for local data: Magellan, Horizon Recovery, BRFSS, YRBS, County Attorney's Office, Region 3, South Central Behavioral Services, Network of Care for Behavioral Health
Target: Developmental

- Increase awareness of available mental health services by 10%
Strategy: Education, Awareness and Promotion; **Strategy:** Resource Network / Database
Baseline: 35.8% (source: Schmeckle, 2012)
Target: 40%
- Decrease stigma as a barrier to accessing services.
Strategy: Integrated Care (HRSA Project); **Strategy:** Education, Awareness, Promotion
Baseline: 62.9% (source: Schmeckle, 2012)
Target: 56.6%

Mental Health Strategies

MH-1. Screening Across the Lifespan

- A. Promote screening for behavioral health, depression, substance abuse, and suicide
- B. Increase venues where screening is available; provide Screening, Brief Intervention, Referral for Treatment (SBIRT) education/training to primary care providers and others
- C. Target at risk populations (youth, college age, pregnant and postpartum women, veterans, seniors) and general adult population
- D. Provide education, awareness, and promotion of screening across the lifespan

MH-2. Integrated Care

- A. Support HRSA-funded Integrated Care Project
 - Pilot Integrated Care model in rural clinic settings
 - Facilitate implementation of policies that reduce billing/payer barriers and elevate mental health services on par with primary care
 - Pursue and secure funding for integrated care implementation
- B. Provide education, awareness, and promotion of integrated care

MH-3. Resource Network/Database

- A. Partner in the development or identification of a database system or search engine for local information and include links with state and national online resources when applicable, i.e., NE DHHS. Tools: Community Resource Guide on SHDHD website, Network of Care for Behavioral Health, Network of Care for Public Health
- B. Prioritize areas of data collection and resources; organize into a database system or add to existing publically accessible database system
- C. Provide resource network training to partners, referral organizations, community based behavioral health and health care services
- D. Provide education, awareness and promotion of resource network and mental health data

MH-4. Mental Health First Aid

- A. Provide mental health education (include screening assessment and medication management as appropriate) and mental health first aid training to school and college counselors, home health, nursing home and assisted living staff
- B. Provide education, awareness, and promotion of mental health first aid

MH-5. Education, Awareness, Promotion (also a component of the other strategies)

- A. Support local activities that decrease stigma and increase awareness of mental health as a critical component of overall community wellness
 - Mental Health Awareness dinner (MLH), presentations at senior centers (MAAA as partners), Active Minds, ASAP Quarterly Breakfasts, Suicide Prevention Coalition / QPR Trainings, community presentations about mental health issues, including traumatic brain injury and substance abuse causes, symptoms, impact, value of screening, etc.
- B. Partner for public education and messaging in all variety of media describing local healthy living resources and how best to access them cost effectively
 - Mental health and substance abuse services
 - Appropriate use of hospital emergency rooms
 - Substance abuse, risk factors, disorder, community services

C. Promote mental health and screenings

- Include with healthy habits at health fairs, combined multi-agency events, and worksite wellness activities
- Build on Head Start ASQSE assessments to reach families and replicate models to other health/support programs serving young families (e.g., WIC)
- Develop/Implement family-focused mental health programs building on Healthy Beginnings, Good Beginnings and parenting education programs
- Youth sports camps and other extracurricular activities

D. Promote recovery support programs and prevention programs/services

- NAMI peer support, community support, support groups, VA-sponsored, Vocational Rehab, etc.
- Active Minds, Girls in Action, Tigers on the Run, Youth Mentorship programs (Teammates, Big Brothers/Big Sisters), crisis response systems, stress management



Priority Goal: Substance Abuse

Goal 4: Reduce substance abuse to protect the health, safety, and quality of life for all, especially young people

Targets/Performance Measures

Youth Targets: Based on standards set by Healthy People 2020, targets were set to achieve a 6% improvement over the next 6 years. Local data: YRBS, 2012

- Decrease the proportion of high school students who reported use of alcohol in the past 30 days.
Baseline: 24.2% (27% State)
Target: 22.75%
- Decrease the proportion of high school students who reported use of marijuana in the past 30 days.
Baseline: 12.3% (13% State)
Target: 11.5%
- Decrease the misuse or abuse of prescription drugs among high school students.
Baseline: 11.8% (12% State)
Target: 11.1%
- Reduce the proportion of adolescents who report riding in the past 30 days with a driver who had been drinking alcohol
Baseline: 22.7% (24% State)
Target: 21.3%
- Decrease the proportion of high school students who reported texting or email while driving.
Baseline: 38.7% (45% State)
Target: 36.4%

Adult Targets: Based on standards set by Healthy People 2020, targets were set to achieve a 6% improvement over the next 6 years. Local data: BRFSS, 2011.

- Reduce the proportion of adults (18+) who reportedly engaged in binge drinking in the last 30 days.
Baseline: 22.8% (22.7% State)
Target: 21.4%
- Increase the percentage of current smokers who reportedly attempted to quit smoking in the past year.
Baseline: 47.9% (55.6% State)
Target: 50.8%

Substance Abuse Prevention Strategies

SA-1. Community Partnerships: Increase community-based public awareness/education activities about substance use that lead to informed policymaking.

Setting: Community

- A. Increase the number of community partners involved in the implementation of the Community Health Improvement Plan (CHIP)
 - Broaden ASAAP, County Substance Abuse Coalition, and Community & College Task Force memberships and partnerships to include judicial officers, businesses (including retailers), faith-based community members, youth mentoring programs, PTOs, Booster Clubs, school boards, worksites/employers, Latino population, and others needed to support the strategies in this plan
 - Support efforts of College/Community Task Force, County Substance Abuse Coalitions, and other community-based substance abuse prevention organizations
- B. Conduct community forums about critical issues (e.g., Life of an Athlete/Pure Performance, community impact of legalization of marijuana in CO, parent and adult behavior modeling, bullying, distracted driving)
- C. Use evidence-based small media/group education to reach target populations with accurate and consistent messaging that raises awareness on facts and perceptions on local substance use and prepares ground for policy change
- D. Engage community decision-makers to consider environmental changes and development of policies that promote prevention and healthy choices (e.g., healthy beverage choices for fundraisers and community events, tobacco/substance free parks, school-based codes of conduct for participation in activities)
- E. Expand pharmaceutical take back program
 - Recruit additional partners and venues for National Drug Take Back events (e.g., senior centers, nursing homes, local law enforcement, pharmacies, primary care clinics)
 - Work with partners to investigate opportunities for more frequent or on-going drug take back

SA-2. Empowered People: Increase evidence-based substance abuse prevention and early intervention activities for youth and college-age students and young adults.

Setting: Schools, Community

- A. Increase community partners involved in prevention and early intervention activities (e.g., Early Head Start, WIC, Healthy Beginnings/Good Beginnings) and support youth activities and mentoring programs that encourage prevention (TeamMates, Big Brothers/Big Sisters, The Zone, S.T.A.R.S., Girls in Action, Tigers on the Run, CASA, etc.)
- B. Expand evidence-based substance abuse programming in elementary and high schools (e.g., ASAAP prevention classes, Pure Performance, Coordinated School Health)
- C. Educate and engage parents (e.g., "I Pledge No" Campaign, Safe Homes, Peer Leadership program, coordinated school health, positive community norms campaigns)
- D. Initiate positive community norms campaign targeted to college communities and general public.

SA-3. Increase access to substance abuse screening, treatment and prevention services.

Setting: Providers, Community

- A. Investigate need and potential for expanded treatment services for juveniles.
- B. Increase community-based services in rural communities through training, funding and partnership opportunities (e.g., integrated behavioral health and primary care initiative), and technology supports (e.g., telehealth).
- C. Promote trauma-informed care in provider and service organizations.
- D. Provide Screening, Brief Intervention, Referral for Treatment (SBIRT) training to area hospital/primary care clinic staff and providers



Priority Goal: Access to Health Care

Goal 5: Improve access to comprehensive, quality health care services

Targets/Performance Measures

Short-term: Local targets were set to achieve a 6% improvement over the next 6 years, consistent with the target of 10% change over 10 years set by Healthy People 2020.

Notes: *District data statistically different from State data. Reference: Data- BRFSS, 2012 (adults, >18 years)

- Increase the proportion of persons with a personal doctor or health care provider.
Baseline: 88.2% (State 82.8%)*
Target: 93.5%
- Increase the proportion of persons who report visiting the doctor for a routine exam in the past year.
Baseline: 60.3% (State 58.0%) [note: BRFSS, 2009-2010]
Target: 63.6%
- Decrease the proportion of persons aged 18 – 64 years without healthcare coverage.
Baseline: 19.3% (State 18.0%)
Target: 18.1%
- Decrease the proportion of persons reporting cost as a barrier to visiting a doctor in the past year.
Baseline: 9.5% (State 12.8%)
Target: 8.4%
- Increase the proportion of persons who report visiting a dentist for any reason in the past year.
Baseline: 67.9% (State 67.6%)
Target: 72.0%

Long-term:

- Increase the number of medical home model clinics (patient-centered medical homes) within the district.
- Developmental
Baseline: 0
Target: 1
- Develop a Community Health Worker (CHW) program/system to increase the number of Community Health Workers serving as bridges between providers of health services and the community. -
Developmental
Baseline: No program available in the district
Target: Program/system in place which provides training and oversight in core competencies, educates on and promotes CHW utilization by providers of health care services and the community
- Increase the available access points across the district for those seeking behavioral health care. -
Developmental
Baseline: (Need to determine a baseline – use private provider list from Region 3 plus SCBS and ML Behavioral Health)
Target: Add access in at least one primary care clinic
- Adoption of EHR technology that meets meaningful use criteria, Health Information Exchange (NEHII), telehealth, and other technology upgrades that support and improve access to health care services.-
Developmental

- Increase the number of Health Literate Organizations - organizations that make it easier for people to navigate, understand, and use information and services to take care of their health. - *Developmental*
Baseline: Need to assess # of organizations meeting the 10 attributes of a health literate organization (Brach, et al., 2012)
Target: South Heartland District Health Department, all 3 hospitals, and at least 1 clinic in each county meet 80% of the attributes of a health literate organization.
- Create a web-based resource for reliable, local health information and resources related to healthy choices and disease prevention, diagnosis, treatment, and management. - *Developmental*
Baseline: Individual stakeholder websites and SHDHD *Network of Care* website for local health status data
Target: One-stop, searchable, comprehensive, linked network of resources and health information
- Support community education and recruitment efforts for health care professions. - *Developmental*

Access to Health Care Strategies

AC-1. Community Partnerships: Expand the number of community partners involved in the implementation of the Community Health Improvement Plan (CHIP).

Setting: Community

- A. Increase the number of local providers that are addressing access to care issues
- B. Increase the number of organizations providing services and resources for populations with low incomes
 - Outreach, educational programming and Q&A support groups (English/Spanish), health system navigation, sliding fee scales, Medicaid providers
 - Potential partners: homeless shelters, faith-based organizations, DHHS (ADC)
- C. Increase # of organizations serving as community connections and communication channels for traditionally underserved populations.
 - Potential partners: Latina Leadership group, MulticulturalHastings.org, Head Start, Project Homeless Connect
- D. Increase # of local businesses who contribute to the CHIP through worksite wellness, health policies, and health insurance options

AC-2. Preventive Services: Increase the ability of all residents to secure and utilize preventive services.

Setting: Community

- A. Establish measurement tools and methods to track establishment and use of “medical homes” by community residents (e.g., BFRSS question?)
- B. Support local efforts to develop community health facilities that follow the Medical Home model (personal physician, expanded access, whole person orientation, coordinated/integrated care across all elements of health care system and the patient’s community, etc.)
- C. Encourage local healthcare providers to offer extended hours for appointments or adjust hours to accommodate working families
- D. Increase access to care through worksites
 - Encourage more local businesses to provide flex-time or time off to accommodate health appointments
 - Increase # of local businesses that provide comprehensive education to their employees about the health services offered under company insurance plans. Include business/community partnerships.
- E. Increase # of organizations providing services, communications channels or community connections for populations with low incomes or who are otherwise traditionally underserved (to include undocumented residents)
 - Deliver easy to understand explanations to clients/members about health services they are entitled to receive under the Affordable Care Act
 - Assist clients/members in connecting with covered services. (MLH- sliding fee scale, care coordinators at homeless shelters, insurance navigators)
- F. Support access to care for smaller communities through development and maintenance of satellite clinics and/or provide transportation or telemedicine.
- G. Continue to work with partners across central Nebraska to support the development of a Federally Qualified Health Center in the region to include oral health, behavioral health, and primary care services

AC-3. Technology Enhancement: Increase the number of local providers using technology to improve access to care.

Setting: Healthcare

- A. Support provider efforts to adopt electronic health records systems
- B. Assist providers to adopt and use telehealth technology to link patients with specialists where appropriate
 - Identify funding and training

- Identify additional opportunities for Hospital outreach through telemedicine clinics (current initiatives: Endocrinology, Obesity, Mental Health, etc.)
- C. Upgrade technology in rural hospitals and clinics
- Explore funding resources (Helmsley Trust, etc.)

AC-4. Empowered People: Empower the general public, referral agents, and communities to connect with and recruit needed resources and reliable health information.

Setting: Community, Health Care Services

- A. Partner in the development of a database system/search engine of local information for public and referring organizations and include links with state and national online resources (e.g., NeDHHS)
- Explore partners/tools: Economic Development, SHDHD’s Community Resource Guide (on SHDHD website), Network of Care website for public health resources, Hastings Public Library, hospitals, United Way model
 - Collaborate with the local library system to enhance available healthy living resources and serve as a channel for educational healthy living programming
- B. Provide consistent public education messaging through program partners and in all varieties of media describing local healthy living resources (including dental health, mental health and substance abuse services) and how best to access them cost-effectively (include education about appropriate use of hospital emergency rooms, dental health and substance abuse)
- C. Implement a Health Literacy Initiative across the district
- D. Increase the base of trained/certified community health workers providing peer to peer education, navigation of healthcare services, and connection to community resources
- Participate in Statewide initiative to develop CHW program
 - Explore/define roles for nurse navigators, insurance navigators
- E. Assist target populations, including traditionally underserved and seniors, in accessing healthcare and related support services
- Support/Enhance/Develop community transportation programs that provide health and wellness transportation services
 - Provide information/referral on Affordable Care Act, managed care plans and insurance navigation (Potential partner: Mid-Nebraska Community Action)
- F. Develop and recruit health and allied health professionals and EMS to meet community needs
- Support local education programs to grow the base of CNAs and certified medical interpreters (explore AHEC scholarships; BMH Scholarships through local high schools and employee scholarship programs; partner w/ CCC)
 - Partner in economic development efforts to strengthen local health-related internship opportunities, and recruit needed healthcare providers to the community (including dental health, mental health and substance abuse treatment professionals)

Reference Documents

Local:

- The South Heartland District Community Needs Assessment Report, 2012: A Four-County Needs Assessment using the Mobilizing for Action through Planning and Partnerships (MAPP) Process.

Framework:

- Frieden, T.R., 2010. A Framework for Public Health Action: The Health Impact Pyramid. American Journal of Public Health. Vol.100 (No. 4): 590 – 595.
- Mobilizing for Action through Planning and Partnerships. Achieving Healthier Communities through MAPP: A User's Handbook. National Association for County and City Health Officials.

Nebraska Plans:

- 2011-2016 Nebraska Physical Activity and Nutrition State Plan (www.partnersnhealth.org/healthyeating)
- Nebraska Comprehensive Cancer Control State Plan 2011-2016 (www.necancer.org/images/stateplan2011_2016.pdf)

National Plans and Evidence-Based Strategies:

- CDC's Winnable Battles (www.cdc.gov/winnablebattles/)
- Centers for Disease Control and Prevention. Recommended Community Strategies and Measurements to Prevent Obesity in the United States. MMWR 2009;58(No. RR7):1-30.
- Healthy People 2020 (HealthyPeople.gov).
- HHS Strategic Plan 2010 – 2015 (www.hhs.gov./secretary/about/stratplan_fy2010-15)
- Leading Change: A Plan for SAMHSA's Roles and Actions 2011–2014 (store.samhsa.gov/product/SMA11-4629)
- National Prevention Council Action Plan: Implementing the National Prevention Strategy (www.surgeongeneral.gov/initiatives/prevention/2012-mpc-action-plan.pdf)
- Obesity: Halting the Epidemic by Making Health Easier. At A Glance 2011. (www.cdc.gov/chronicdisease/resources/publications/aag/obesity/htm.)

- Recommended Community Strategies and Measurements to Prevent Obesity in the United States: Implementation and Measurement Guide (July 2009) (www.cdc.gov/obesity/downloads/community_strategies_guide.pdf)
- School Health Programs: Improving the Health of Our Nation's Youth. At A Glance 2011. (www.cdc.gov/chronicdisease/resources/publications/aag/dash.htm)
- The Community Guide (www.thecommunityguide.org)



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